Calvary | Health Care Kogarah

Calvary Rehabilitation Medical Referral

Dr Helani Levand   Dr Matthew Gardiner
Dr Kathryn Brooke   Dr Kenneth Chan

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

Surname ____________________ MRN: __________
Given Name ____________________ ☐ M ☐ F
D.O.B. _____/_____/_______ M.O. ______________
Address ________________________________
____
Location / Ward ________________________

(please tick)
☐ **For Day Rehabilitation Unit, fax 02 9553 3109**

(please tick)
☐ **For Inpatient Rehabilitation, fax 02 9553 3112**

Referral Date: ____________ **Referrer's Name:** ______________ **Designation:** ____________
Provider Number: __________ **Signature:** __________________ **Contact Number:** __________
Anticipated Date for Admission: ____________ **Present Location:** ______________________
Person Responsible: ______________ **Relationship:** ______________ **Phone Number:** __________
Indigenous Status: ☐ Neither ATSI ☐ Aboriginal ☐ Torres Strait Islander ☐ Both

Chief Impairment / Operation:

Hb: _____ **Date:** _________

Co-Morbidities:

Weight: ____________ Kg
☐ Home O_2 ☐ PICC/CVC/Drain

Continence Status: ☐ Continent ☐ Incontinent Bladder ☐ Incontinent Bowel ☐ IDC ☐ SPC ☐ Colostomy

Current Diet: **Diabetes** ☐ Yes ☐ No **Allergies** ☐ Yes ☐ No ☐ **PEG** Regime ______________

Cognitive Status: ☐ **Normal** ☐ **Chronic Confusion:** ☐ **Mild** ☐ **Moderate** ☐ **Severe** ☐ **MMSE** ________ **(if Pt >65 or confused)**

Infectious status: **MRSA** ☐ Yes ☐ No **VRE** ☐ Yes ☐ No **Other:** ______________________

Usually resides with: ______________ **Language Spoken:** __________ **Interpreter Required:** ☐ Yes ☐ No
Usual Residence: ☐ Private House ☐ Unit/flat ☐ Retirement Village ☐ Nursing Home ☐ Hostel

Access: ☐ Steps/Stairs ☐ Front ________ rail _______ ☐ Rear ________ rail _______ ☐ Internal _______ rail _______ ☐ Lift

Premorbid Status

Mobility Aid: ☐ Independent ☐ Supervision ☐ Assistance **Number of Falls Last Year:** ____________
Personal care: ☐ Independent ☐ Supervision ☐ Assistance
Service: ☐ HCP Level _______ ☐ MOW / Compacks ☐ Community Nurse ☐ Advance Care Plan ☐ Other ____________

Current Mobility Status:

Transfers/Sit to Stand:	☐ **Independent**	☐ **Supervision**	☐ **Assistance**	☐ **Hoist**	
Bed Mobility:	☐ **Independent**	☐ **Supervision**	☐ **Assistance**	☐ **Hoist**	
Ambulation:	☐ **FASF**	☐ **PUF/Walker**	☐ **Crutches**	☐ **Stick(s)**	
	☐ **Independent**	☐ **Supervision**	☐ **Assistance** _____	person(s) min / mod / max	
Weight Bearing Status:	☐ **(R) UL**	☐ **(L) UL**	☐ **(R) LL**	☐ **(L) LL**	
	☐ **FWB**	☐ **WBAT**	☐ **PWB**	☐ **TWB**	☐ **NWB** for ______ more weeks

Skin Integrity: **Wound:** ☐ Yes ☐ No **Pressure Injury:** ☐ Yes ☐ No
Grade: _________ **Location:** _______ **Dressing:** ______________
Wheelchair Use: ☐ Yes ☐ No **Describe W/C Needs:** **Specialised Equipment Required:** ______________

Worker's Compensation / Motor Vehicle Claim Details:

Other Relevant Information/Investigations/Behavioural Issues?

Additional information required for DRU Admission: **Transport Required:** ☐ Yes ☐ No (pending availability)
Assistance required to transport from home/DRU to bus: ☐ Yes ☐ No **Suitable for Hydrotherapy** ☐ Yes ☐ No

For enquires please contact:* 9533-3111 *(Inpatient Rehabilitation Unit)* / 9553-3023 *(Day Rehabilitation Unit)

DO NOT WRITE IN MARGIN

CALVARY HEALTH CARE SYDNEY REHABILITATION UNIT REFERRAL FORM

CHCK 060.999G